State of Idaho
Division Of Occupational and Professional Licenses
Board of Nursing

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

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P.O. Box 83720
Boise, ID 83720-0063
(208) 334-3233
dopl.idaho.gov

EMPLOYMENT VERIFICATION FORM

Instructions

1. If you have practiced as a nurse within the last 2 years, complete this form and send it to your most recent place of employment to verify the **dates you have worked as an LPN/RN or APRN,** *we do not want your license dates*.
2. If you have graduated from a nursing education program within less than a year, and have not yet practiced, send this form to your education program to verify clinical experience dates.
3. If you have completed mandated remediation, complete this form and have your RN supervisor verify clinical hours.
4. **NOTE: Employment can NOT be projected into the future, if you are currently working put "present" in the "To Mo/Yr"**

Authorization for Release of Information to the Idaho Board of Nursing - To be completed by Applicant

Employer/Educational Institution

Name of Organization/Institution

Name of Supervisor/Nursing Education Administrator

Individual Authorizing Release

First, Middle, Last name of nurse applicant

Position/License Type Held | *From Mo/Yr* | *To Mo/Yr*

Phone/email address

I am applying to be licensed as a nurse in Idaho. As part of the process, it is necessary to verify I have practiced nursing within the last three years. **I am attesting to having practiced in your organization with the license type during the time frame noted above.**

By my signature, I hereby authorize release of the information requested below.

Printed name | *Signature* | *Date*

Verification of Nursing Practice (Employment) - To be Completed by Employer

Name of Organization/Institution

Name of Supervisor/HR Representative/Nursing Education Administrator

Phone

Mailing Address

City, State, Zip

Email

By my signature, I verify the above-named applicant was employed/enrolled with this organization in the capacity and for the dates entered below. *Note: if student is selected please also check an additional field for level of school applicant was in.*

From Mo/Yr | *To Mo/Yr*

- ☐ Licensed Practical Nurse (LPN)
- ☐ Licensed Registered Nurse (RN)
- ☐ Student
- ☐ APRN:
  - ☐ CNM
  - ☐ CNS
  - ☐ CNP
  - ☐ CRNA

Title | *Signature* | *Date*

Please return this document to the Idaho Board of Nursing by Email:
hp-licensing@dopl.idaho.gov

Phone: (208) 577-2476

Note: This form will not be accepted if submitted by the applicant.